SECTION 3A

Skilled nursing facility services

RECOMMENDATION

The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2008.

COMMISSIONER VOTES: YES 14 • NO 0 • NOT VOTING 0 • ABSENT 3

SECTION 3A

Skilled nursing facility services

Section summary

Our indicators of payment adequacy are generally positive for skilled nursing facilities (SNFs), but two quality measures show decline. Beneficiaries have good access to SNF care, although those who need certain expensive services may experience delays in finding SNF care. The number of facilities providing SNF care to Medicare beneficiaries has remained almost constant—declining by less than 0.1 percent in 2006. Spending and volume of days and stays increased in 2005, with case mix continuing to shift to high-payment rehabilitation case-mix groups. Two outcome measures for Medicare SNF patients show declining quality in recent years: Average facility rates of avoidable rehospitalizations increased and discharges to the community declined. SNFs appear to have good access to capital. Medicare payments more than cover the costs of providing SNF care to Medicare beneficiaries in 2007. ■

In this section

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Recommendation 3A

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Background

Medicare beneficiaries qualify to receive covered services in a skilled nursing facility (SNF) if they need short-term skilled nursing care or rehabilitation services on a daily basis in an inpatient setting. For a spell of illness, Medicare provides coverage for up to 100 days after a medically necessary hospital stay of at least 3 consecutive days.[1] Covered SNF services include: skilled nursing care; rehabilitation services such as physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services; and other ancillary services such as medications and respiratory therapy. Other ancillary services are often referred to as nontherapy ancillary services to distinguish them from the therapy-related ancillary services for which the SNF prospective payment system (PPS) makes explicit payments. The Medicare program pays separately for some services, such as certain chemotherapy drugs and customized prosthetics and orthotics, which are excluded from the SNF daily rate. Medicare's daily rates under the PPS for SNFs apply to all (routine, ancillary, and capital-related) costs of covered SNF services. Medicare pays 100 percent of the payment rate for the first 20 days of a SNF stay. From day 21 to day 100, beneficiaries are responsible for a copayment of $124 per day in calendar year 2007.

Beneficiaries who qualify may be admitted for a Part A stay for rehabilitative and recuperative care provided in SNFs that meet Medicare's conditions of participation and agree to accept Medicare's payment rates. The conditions of participation relate to many aspects of staffing and care delivery in the facility, such as requiring a registered nurse in the facility for 8 consecutive hours per day and licensed nurse coverage 24 hours per day; providing rehabilitative services, such as physical and occupational therapy, as required in patients' plans of care; and providing or arranging for physician services 24 hours a day in case of an emergency.

The most common diagnosis for a SNF admission in 2004 was a major joint and limb reattachment procedure of the lower extremity, typically a hip or knee replacement.[2] Ten conditions accounted for 38.3 percent of all admissions to SNFs in 2004 (Table 3A-1). Freestanding and hospital-based facilities and nonprofit and for-profit facilities had the same top 10 diagnoses in the same rank order.

Medicare spending on skilled nursing facility services

Between fiscal years 2004 and 2005, Medicare spending for SNF services grew 8 percent to $18.5 billion (OACT 2006), which is slightly less than the average annual rate of growth of 11 percent per year between fiscal years 2000 and 2005. During this five-year period, however, year-to-year spending growth varied. Temporary payment add-ons contributed to higher year-to-year growth during the period, while the expiration of some temporary payments contributed to spending declines. For example, from 2000 to 2001 spending grew 18 percent. This large increase

TABLE 3A–1

Most common diagnoses among Medicare SNF patients account for more than a third of patients in 2004

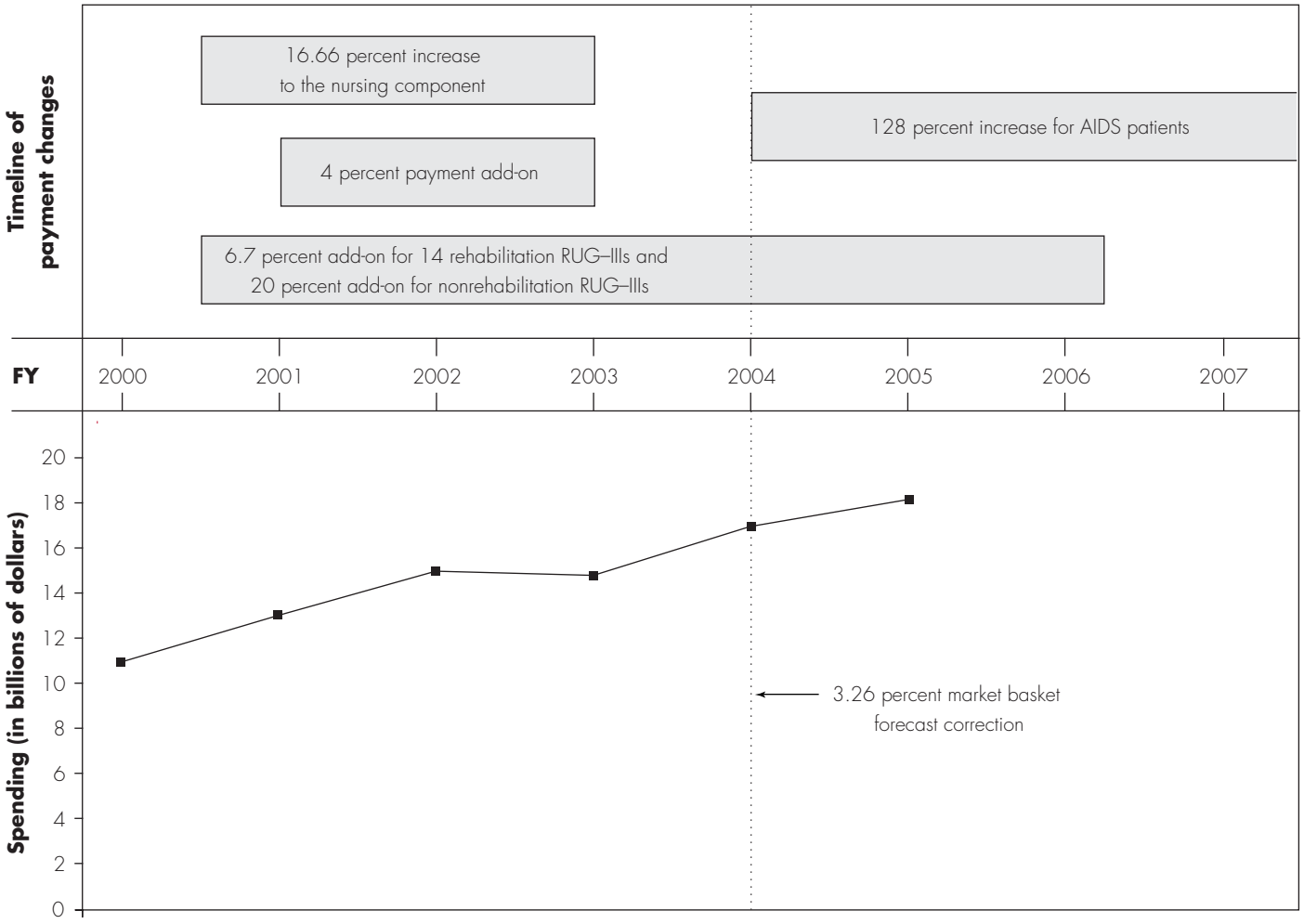
Diagnosis code from hospital stay	Diagnosis	Share of SNF admissions
209	Major joint and limb reattachment of lower extremity	7.1%
127	Heart failure and shock	5.1
089	Simple pneumonia and pleurisy, age >17, with CC	5.1
210	Hip and femur procedures except major joint, age >17, with CC	4.1
014	Intracranial hemorrhage and stroke with infarction	3.4
320	Kidney and urinary tract infections, age >17, with CC	3.1
416	Septicemia, age >17	3.1
296	Nutritional and miscellaneous metabolic disorders, age >17, with CC	2.8
079	Respiratory infections and inflammations, age >17, with CC	2.5
088	Chronic obstructive pulmonary disease	2.0
	Total	38.3

Note: SNF (skilled nursing facility), CC (complication or comorbidity). The diagnosis code from hospital stay is the discharge diagnosis.

Source: MedPAC analysis of DataPRO file from CMS. 2004.

FIGURE 3A–1

Year-to-year changes in Medicare payments for skilled nursing facility services reflect temporary payment changes



Note: RUG–III (resource utilization group, version III), FY (fiscal year). Data are program spending by federal fiscal year.

Source: Spending data are from CMS, Office of the Actuary 2006.

coincided with implementation of several temporary payment add-ons in fiscal year 2001 (Figure 3A-1). SNF spending fell nearly 4 percent between 2002 and 2003, coinciding with the expiration of two add-ons at the end of fiscal year 2002. Spending rebounded in 2004, when the base rate increased by the full market basket amount (3 percent) plus another 3.26 percent that year to correct for cumulative market basket forecast error since implementation of the PPS. Volume growth also contributed to spending changes from year to year, but like payment increases, volume growth also varied. Year-to-year growth in total patient days during the period ranged from a high of 14 percent between 2001 and 2002 to a low of 5 percent between 2003 and 2004.

How does the Medicare SNF payment system work?

Medicare's PPS for SNF services started with cost reporting periods beginning on July 1, 1998, and was fully phased in by 2001.[3] Under the PPS, the daily payment rates for SNFs were set in 1998 to reflect SNF costs in 1995, updated for inflation. The base rates cover routine, ancillary, and capital-related costs and are updated annually based on the projected increase in the SNF

Labor cost and case-mix adjustment

Daily payments to skilled nursing facilities (SNFs) are determined by adjusting the base payment rates for geographic differences in labor costs and case mix. To adjust for labor cost differences, the labor-related portion of the total daily rate—76 percent for fiscal year 2007—is multiplied by the hospital wage index in a SNF's location and the result is added to the nonlabor portion. The daily base rates are adjusted for case mix using the resource utilization group, version III (RUG–III) classification system, which has 53 groups. The groups can be classified into two categories: rehabilitation (patients receiving between 45 and 720 or more minutes of therapy per week) and nonrehabilitation (patients generally receiving less than 45 minutes of therapy per week). Each of the 53 RUG–IIIs has associated nursing and therapy weights to adjust the base payments up or down depending on the resources associated with each type of patient. The nursing base rate is case mix adjusted for all RUG–IIIs. The therapy base rate is case mix adjusted for rehabilitation RUG–IIIs and is a constant amount for nonrehabilitation RUG–IIIs. The payment for items such as room and board and linens is a fixed amount for all patients regardless of case-mix group.

Patients are assigned to one of the 53 RUG–IIIs based on patient characteristics that are expected to require similar resources. Assignment of a beneficiary to a RUG–III is based on the number of minutes of therapy (physical therapy, occupational therapy, or speech-language pathology services) the patient has used or is expected to use; the need for certain services (e.g., respiratory therapy or specialized feeding); the presence of certain conditions (e.g., pneumonia or dehydration); an index based on the patient's ability to perform independently four activities of daily living (eating, toileting, bed mobility, and transferring); and in some cases, signs of depression. Patients' characteristics and service use are determined by periodic assessments using the SNF patient assessment instrument, known as the Minimum Data Set. (More information about the prospective payment system for SNFs is available at http://www.medpac.gov/publications/other_reports/Sept06_MedPAC_Payment_Basics_SNF.pdf.) ■

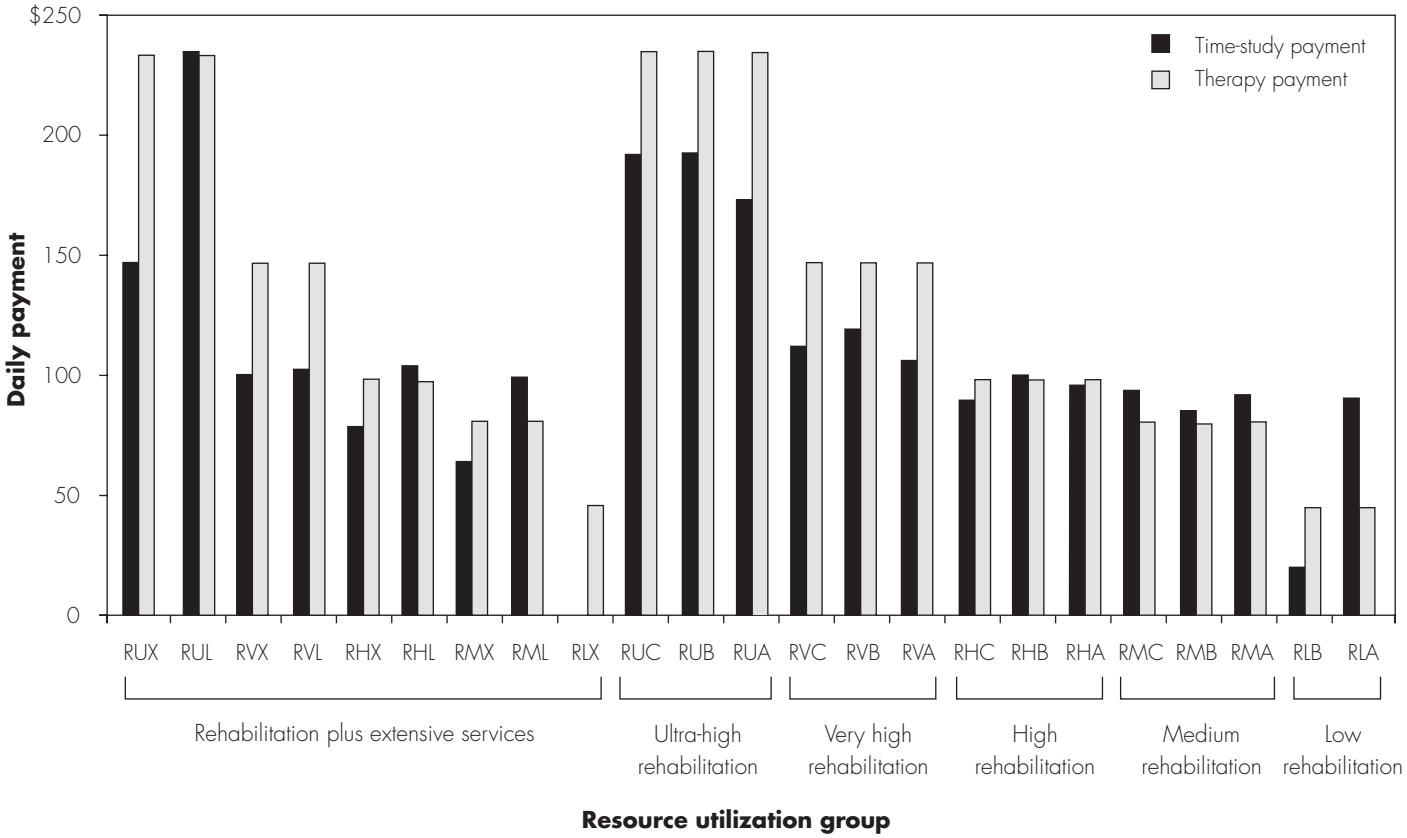
market basket index, a measure of the national average price for the goods and services SNFs purchase to provide care.[4] The total Medicare daily payment rate for SNF services is the sum of three base rate components, which were computed separately for urban and rural areas per the Balanced Budget Act of 1997 (BBA) that mandated the PPS for SNFs:

- a nursing component, reflecting nontherapy ancillary service costs (explained in more detail later) and the intensity of nursing care that patients are expected to require;
- a therapy component, reflecting the amount of therapy services (physical and occupational therapy and speech-language pathology services) provided or expected to be provided; and
- a component reflecting the costs of room and board, linens, and administrative services.

The BBA required that Medicare's prospective payment bundle for SNFs include payment for nontherapy ancillary services, such as drugs and respiratory therapy. CMS used the total cost of these services to develop the nursing component of the base rates. However, nontherapy ancillary service costs were not used to develop the case-mix system—resource utilization group, version III (RUG–III)—that adjusts payments up or down depending on use of services and patient characteristics (see text box). As a result, the case-mix system distributes payments for nontherapy ancillary service costs in the same manner that it allocates payment for nursing care costs. Because some nontherapy ancillary services (e.g., intensive intravenous (IV) antibiotic therapy, or ventilator care) involve costs that greatly exceed the payments as distributed by nursing component weights, daily payments are too low for patients using these services, while payments for other patients may be too high (GAO 1999, White et al. 2002).

FIGURE 3A–2

SNF therapy payments based on time study data would differ from actual 2006 payments for rehabilitation RUG–IIIs



Note: SNF (skilled nursing facility), RUG–III (resource utilization group, version III). A time-study payment could not be calculated for RLX (low rehabilitation and extensive services) because there were no patients from the time study in that case-mix group. For additional description of the RUGs, see http://www.medpac.gov/publications/other_reports/Sept06_MedPAC_Payment_Basics_SNF.pdf.

Source: MedPAC analysis of CMS staff time measurement study data.

The 53-group RUG–III case-mix system went into effect January 1, 2006, replacing the 44-group system that had been used to adjust the base rates since the PPS for SNFs was implemented. CMS added nine payment groups for patients who meet the criteria for both the "extensive services" and "rehabilitation" groups.[5] Adding these new groups did not directly address the targeting of payment for nontherapy ancillary services. When the PPS was implemented, case-mix weights for the 44-group RUG–III classification systems were calculated using data collected from time studies in volunteer facilities in 6 states in 1990, 1995, and 1997.

CMS did not collect new data to develop the weights for the additional case-mix groups or recalibrate all the weights of the existing groups for the 53-group RUG–III system. Instead, CMS took different approaches to determining the nursing and therapy weights for the 53-group RUG–III system. To derive the nursing weights, CMS regrouped the time-study observations into the 53 groups and recalibrated all the weights according to salary-weighted minutes of nursing associated with the new groups. For the therapy weights, CMS used the same weights that had been used under the 44-group RUG–III system for the new, as well as the old, groups. For example, the two new "ultra-high rehabilitation plus extensive services" groups and the three remaining "ultra-high rehabilitation" groups have the same therapy weights as the three "ultra-high rehabilitation" groups under the 44-group system, even though—according to the

TABLE 3A–2 **Share of facilities, stays, and payments varies by type of skilled nursing facility**

	Facilities		Medicare-covered stays		Medicare payments	
Type of SNF	**2004**	**2005**	**2004**	**2005**	**2004**	**2005**
Freestanding	91%	92%	85%	87%	92%	93%
Hospital based	9	8	15	13	8	7
Urban	67	67	79	79	81	81
Rural	33	33	21	21	19	19
For profit	67	68	65	66	71	72
Nonprofit	28	28	31	30	25	25
Government	5	5	4	4	3	3

Note: SNF (skilled nursing facility). Totals may not sum to 100 due to rounding.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files.

time-study data—these groups used different amounts of therapy.

As a result, the therapy weights associated with each rehabilitation RUG–III in the 53-group system differ from what they would have been if based on time-study data (Figure 3A-2). For 15 of the rehabilitation groups, the RUG–III therapy payment is higher than the time-study-based therapy payment; for 8 other rehabilitation groups, payments are lower. Without new data to recalibrate the weights of the new categories, it is unclear whether either of these payments—based on the old or recalibrated weights—reflects the average amount and cost of therapy current SNF patients use. CMS needs to collect more current data and calculate new weights, as the Commission has recommended in previous years.

To recalibrate the RUG–III nursing and therapy case-mix weights used to determine payment rates, CMS is studying nursing facility staff time and collecting data for the first time since the PPS was implemented. It is collecting data on staff time and other facility resources used to provide care from a sample of freestanding and hospital-based nursing facilities that treat Medicare and Medicaid patients. The study is also collecting data on health status, medical conditions, and the service use for both post-acute care and long-term care. Data collection began in volunteer facilities in the spring of 2006 and is expected to be completed in 2007. Recommendations for modifications to the RUG–III case-mix weights are expected in late 2007 or early 2008 (CMS 2006).

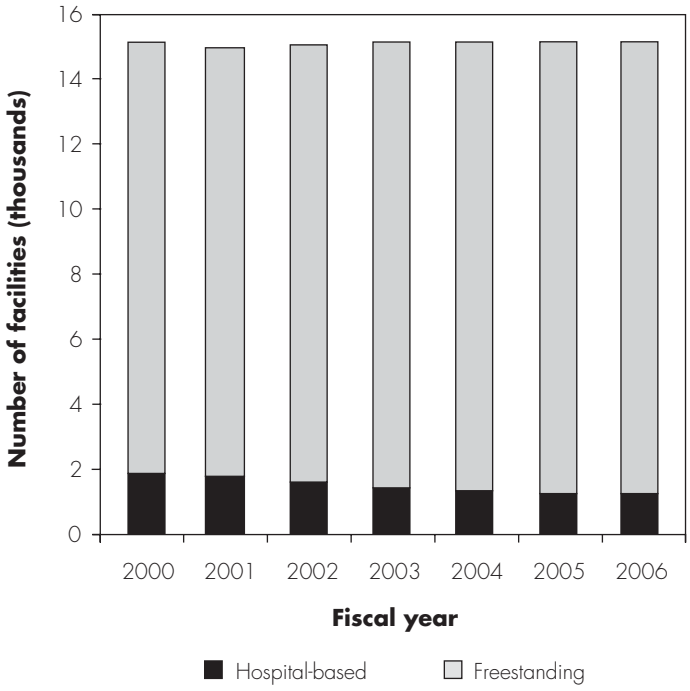
Providers of skilled nursing facility care

SNF services may be provided in freestanding or hospital-based facilities. In 2005, 92 percent of facilities were freestanding and 87 percent of Medicare-covered SNF stays were in freestanding facilities (Table 3A-2). A freestanding SNF is typically part of a nursing home that also provides long-term care, which Medicare does not cover. Patients who are in a freestanding facility for a Medicare-covered SNF stay are typically a small share of the total patient population in a Medicare-participating SNF.

At the median, Medicare-covered SNF days made up 11 percent of total patient days in freestanding facilities in 2005, based on cost report data. Just 10 percent of these SNFs had Medicare shares of 22 percent or more of their total patient days. The remaining patients in freestanding SNFs are non-Medicare skilled nursing care patients or long-term care residents. However, some freestanding facilities have a large Medicare share of patient days. On average, hospital-based SNFs typically serve a large share of Medicare short-stay patients and few long-term care residents, but there are also exceptions to this typical patient mix among hospital-based SNFs as discussed on pp. 178–179.

FIGURE 3A–3

The number of Medicare-certified skilled nursing facilities has remained stable, with more freestanding and fewer hospital-based



Source: MedPAC analysis of data from Certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification's Providing Data Quickly system for 2000–2006.

Are Medicare payments adequate in 2007?

Indicators of payment adequacy are generally positive for SNFs. Beneficiaries have good access to SNFs, although those who need certain expensive services may experience delays in finding SNF care. The number of nursing facilities providing SNF care to Medicare beneficiaries remained almost constant in 2006—declining by less than 0.1 percent. Volume increased in 2005 as measured by SNF stays and days. Two outcome measures for Medicare SNF patients show declining quality: Facility rates of avoidable rehospitalizations increased and the discharges to the community declined. SNFs appear to have good access to capital. Medicare payments more than cover their costs of providing SNF care to Medicare beneficiaries in 2007.

Beneficiaries' access to care

Medicare beneficiaries appear to experience little or no delay in accessing SNF services, especially if they need rehabilitation therapies. On the basis of structured interviews in 2004 with 256 hospital discharge planners who oversee the placement of Medicare beneficiaries into post-acute care settings, the Office of Inspector General (OIG) found that 84 percent of discharge planners in their sample could place all Medicare beneficiaries who needed SNF care (OIG 2006). This was a statistically significant increase from the share (73 percent) in 2001 (OIG 2006).

In spite of generally good access to care, beneficiaries with certain complex or special care needs may remain in the hospital setting longer. As the OIG found in earlier studies of access to SNFs, in 2004 some beneficiaries with certain medical conditions or service needs experienced delays that may lengthen their hospital stay (OIG 2001, 2000, 1999). The OIG found that Medicare patients who needed IV antibiotics or expensive drugs, wound care, ventilator care, or dialysis, or who had behavior problems were harder to place. Discharge planners identified the cost of these services as the cause of the delay in placement. Several of these services—IV antibiotics, drugs, and ventilator care—are the nontherapy ancillary services for which the SNF payment system does not explicitly allocate payments according to variation in patients' costs (White et al. 2002).

Supply of providers

The number of SNFs was nearly the same in 2005 as in 2006, continuing a trend of relatively flat growth in overall SNF supply (Figure 3A-3). Since the PPS for SNFs was implemented, the number of hospital-based SNFs declined and the number of freestanding SNFs participating in the program increased. According to CMS data, 186 freestanding SNFs and 31 hospital-based SNFs began participating with the Medicare program in fiscal year 2006.

Volume of services

Between 2004 and 2005, the volume of SNF services increased (Table 3A-3). Admissions increased by 5 percent to about 2.5 million. This increase translates to 70 admissions per 1,000 fee-for-service enrollees in 2005, compared with 67 the year before. The average number of covered days per SNF admission grew just slightly more than admissions in 2005.

TABLE 3A–3

The number of Medicare admissions and covered days of SNF care is growing and stays are getting longer

	2002	2003	2004	2005	Change 2004–2005	Average annual change 2002–2005
Admissions (in millions)	2.2	2.4	2.4	2.5	5%	5%
Covered days (in thousands)	54,674	59,416	62,364	65,905	6	6
Average days per admission	24.6	24.9	25.8	25.9	0.4	2

Note: SNF (skilled nursing facility).

Source: SNF calendar year MedPAR data from CMS, Office of Research Development and Information.

Between 2004 and 2005, the number of Medicare SNF days increased at different rates among SNF case-mix groups.[6] Two categories of RUG–IIIs, ultra-high rehabilitation and very high rehabilitation, grew as a share of all freestanding Medicare-covered SNF days, while the share of days in all other rehabilitation and nonrehabilitation categories declined. The changes between 2004 and 2005 continue a trend in Medicare beneficiaries becoming even more concentrated in the rehabilitation RUG–IIIs (Figure 3A-4, p. 174). Among rehabilitation groups, the distribution of patients shifted toward the highest payment rehabilitation groups with the most minutes of therapy. Together, the 3 ultra-high rehabilitation and 3 very high rehabilitation RUG–IIIs at the top of the 44-group case-mix hierarchy represent about 42 percent of SNF days in 2005, an increase of 14 percentage points from just 3 years earlier. Additional research is necessary to explore the reasons for volume growth and the shift toward higher rehabilitation payment groups. They could be a function of several factors including changes in the site of service from other settings or favorable payment incentives for treating patients in rehabilitation RUG–IIIs. From available data, we cannot assess whether these shifts toward higher payment groups indicate increased patient needs or whether patients benefit from additional therapy.

As a result of the shift toward higher rehabilitation case-mix groups, the average therapy case-mix index has increased and the average nursing case-mix index has slightly declined among freestanding SNFs. This means that as Medicare spending on SNF services increases overall, the program is paying for relatively more therapy and relatively less nursing and other items, like drugs, included in the nursing portion of the base rate. The program still spends more on the nursing portion than on the therapy portion of the base rate, but the share of the program's SNF dollar going to therapy payments is growing.

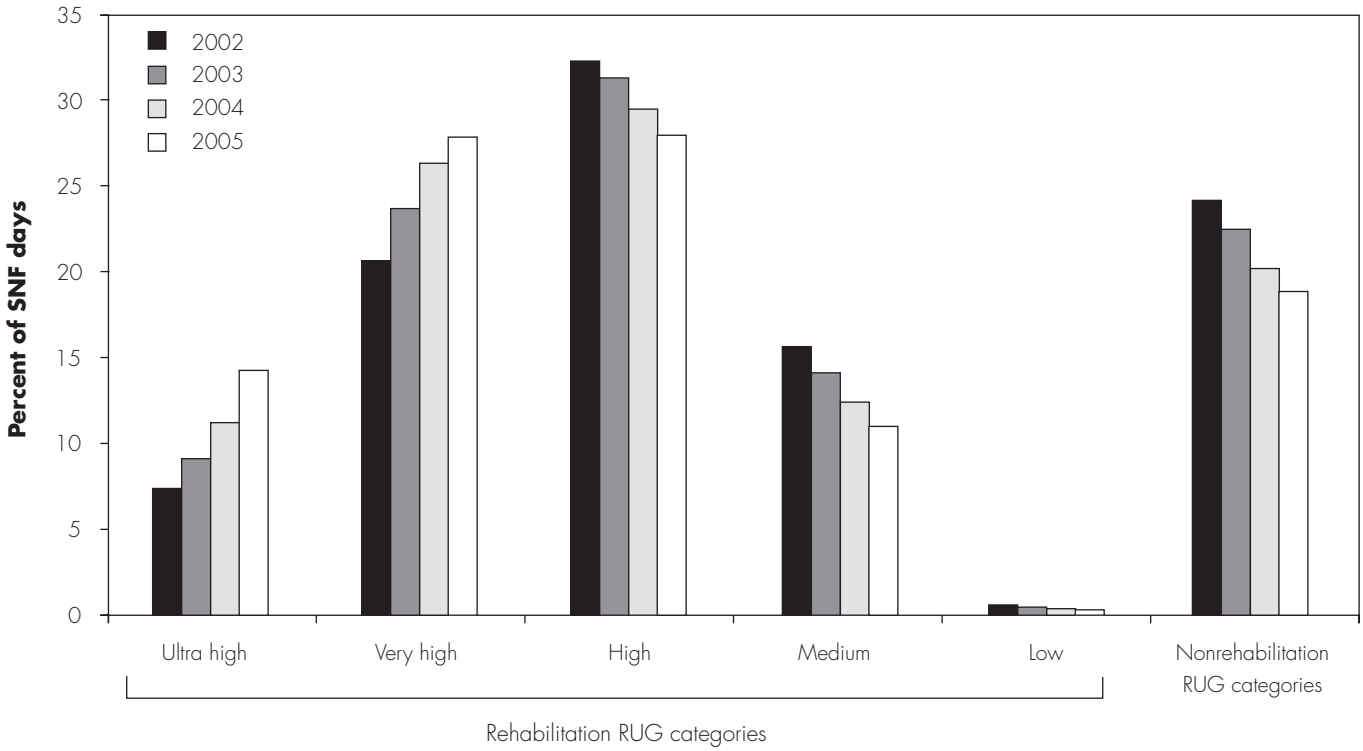
The increasing use of therapy by a large and growing majority of Medicare SNF patients suggests that the population of SNF patients may be changing and adds still another reason for measuring the value of therapy. The Commission has previously recommended measuring functional status at admission and discharge to assess whether patients' status improves. This is one dimension of the value of care for many patients receiving therapy in a SNF (MedPAC 2006, 2005). However, the program does not currently collect data to enable such an assessment. Given the growth in therapy services in SNFs and payment system incentives to provide therapy, CMS should collect data to assess what the Medicare program and Medicare beneficiaries are getting for this spending, as the Commission has recommended in past reports (MedPAC 2006, 2005). In addition, because therapy services are provided in multiple settings and predicting the need for therapy is difficult, understanding the changes in functional status among SNF patients is a critical step to assessing the value of therapy spending and comparing outcomes across post-acute care settings (MedPAC 2006). The home health and inpatient rehabilitation assessment instruments already collect functional status data on patients at admission and discharge.

Quality of care

Two risk-adjusted measures of quality for short-stay patients in SNFs show that the quality of care for patients

FIGURE 3A–4

Case mix in freestanding SNFs has shifted toward a greater share of and higher intensity rehabilitation RUG–IIIs



Note: SNF (skilled nursing facility), RUG–IIIs (resource utilization groups, version III). Days are for freestanding skilled nursing facilities with valid cost report data.

Source: MedPAC analysis of freestanding SNF cost reports.

with a Medicare-covered SNF stay declined between 2000 and 2004 (Figure 3A-5).[7] These measures are facility rates of: (1) potentially avoidable rehospitalization for any of five conditions (congestive heart failure, respiratory infection, urinary tract infection, sepsis, and electrolyte imbalance); and (2) community discharge within 100 days of admission to the SNF.[8] The mean facility rates of rehospitalization within 100 days of admission increased from 11.8 percent in 2000 to 17.0 percent in 2004. Mean facility rates of community discharge within 100 days fell from 33.8 percent in 2000 to 32.8 percent in 2004. However, the mean rate in 2004 shows an increase over 2003, reversing a three-year trend of falling rates (Donelan-McCall et al. 2006).

We use these measures rather than the currently reported Nursing Home Compare measures (facility rates of delirium, pain, and pressure ulcers) for short-stay SNF patients because the currently reported measures have a number of limitations, including sample bias and evidence that the measures are not valid (Abt 2005, Donelan-McCall et al. 2006, MedPAC 2006, MedPAC 2005). In addition to overcoming data limitations, rates of discharge to the community and potentially avoidable rehospitalizations capture important outcomes for patients admitted for a Medicare-covered SNF stay. For many SNF patients, a major goal of SNF care is rehabilitation for functional losses after surgery or extensive medical problems. The primary goals of rehabilitative therapy—which over three-quarters of Medicare SNF patients receive—are recovery of function and often discharge to the community (Donelan-McCall et al. 2006). Evidence of case-mix change also suggests that more patients are receiving more therapy. Avoiding unnecessary rehospitalization is important because the primary treatment goal for many SNF patients is stabilization of medical or postsurgical problems following an acute hospitalization (Donelan-McCall et al. 2006). Reducing

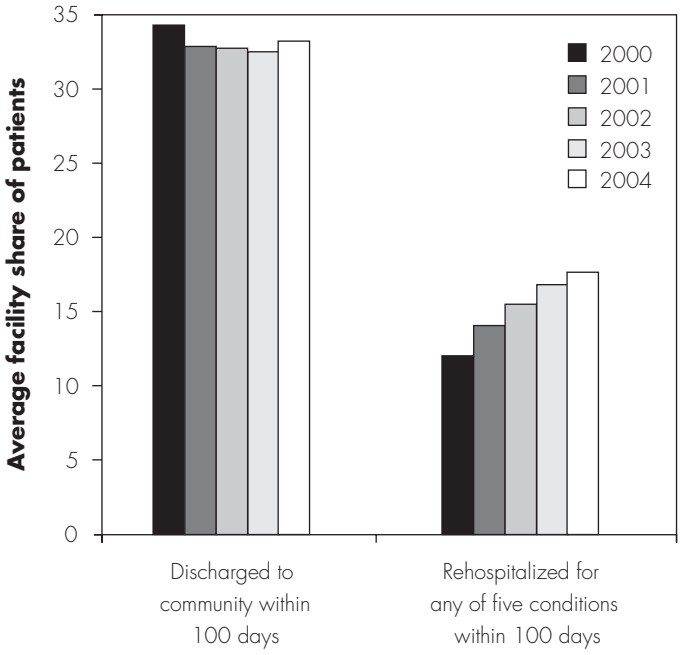
hospitalization for any of the five conditions measured requires the use of preventive measures in the SNF to avoid declining health, the early detection of signs and symptoms of worsening health, and prompt intervention by nursing staff and a physician when needed. Using this measure for reporting may also encourage SNFs not to take patients who are not ready for discharge from the hospital (Donelan-McCall et al. 2006).

When these measures were originally developed for CMS, rates of hospitalization for congestive heart failure, respiratory infection, urinary tract infection, sepsis, and electrolyte imbalance were found to be significantly lower in facilities with higher levels of nurse aides and licensed staff as well as in facilities with higher staff retention, after adjusting for facility case mix (Kramer and Fish 2001). The original study used data from the Medicaid program in states that require detailed data reporting on staffing to explore the relationship between staffing and outcomes. National data on Medicare-participating SNFs' staffing—including nursing costs and staff retention and turnover—are limited, which inhibits analysis of factors that have previously demonstrated a relationship to certain outcomes in SNFs. Given evidence of declining quality of care, collection of more detailed staffing data could answer questions about any relationship between quality and staffing levels, experience, retention, and costs and, in turn, could suggest mechanisms—such as staffing levels or staff training—to improve quality.

The Commission previously recommended collecting nursing cost and staffing information to facilitate the Medicare program's evaluation of the relationship between SNFs' nursing costs, staffing levels, turnover, experience, and quality of care (MedPAC 2004). Currently, SNFs must report total routine costs to CMS on their annual cost reports, but the program does not require separate reporting of nursing staff costs. Because many different kinds of nurses care for patients in SNFs and nursing homes, it would be useful for SNFs to break down the nursing costs by type of nurse (i.e., registered nurses, licensed practical nurses, and nurse aides). In addition, while CMS already collects basic information on nurse staffing in its survey and certification process, more detailed information on staffing by facility (e.g., number of nursing staff by type, including contract nurses, hours worked, and years of experience in the facility) would help evaluate the relationship between staffing, costs, and quality. To capitalize on existing personnel data and to limit reporting burden, CMS could explore using elements in electronic payroll systems to collect detailed staffing data (Kramer 2006).

FIGURE 3A–5

Quality of care in SNFs declined from 2000 to 2004



Note: SNF (skilled nursing facility). The five conditions include congestive heart failure, respiratory infection, urinary tract infection, sepsis, and electrolyte imbalance. Repeated measures analysis of variance for all outcomes measures demonstrated a statistically significant effect ($p<0.0001$) of time. In addition, comparisons between 2004 and all other years (e.g., 2004 and 2000, 2004 and 2001) and between consecutive years (e.g., 2000 and 2001, 2001 and 2002) were statistically significant at $p<0.005$. The exception was community discharge within 100 days between 2002 and 2003. Rates are calculated in each year for all facilities with more than 25 stays.

Source: Donelan-McCall et al. 2006.

Access to capital

Because of the relatively small share of nursing facility patient-days that are covered by the Medicare program and the relatively large share covered by Medicaid, SNFs' ability to access capital may be less attributable to Medicare payments than to Medicaid and private payers. (For additional discussion of Medicaid nursing home payment see the text box, p. 176.) However, given the relative generosity of its rates, Medicare is an important source of revenue for providers of SNF care. Industry analysts we spoke with report that increasing the share of Medicare patients in a facility is one strategy for improving overall financial performance and that, for some of the larger chains, Medicare patients make up a large and growing share of total patients.

Medicaid payment effects on nursing facility margins

As in other sectors, the Commission considers the Medicare margin, rather than total facility margin, to guide its update recommendation for skilled nursing facilities (SNFs). Industry representatives contend that the total margin, including Medicaid payments and costs, provides a more accurate picture of nursing facilities' financial situation than the Medicare margin. On average, Medicare payments accounted for 21 percent of revenues to freestanding SNFs in 2005. However, although they represent a small share of total patients in a facility, on average, Medicare payments are important to the financial bottom line for skilled nursing facilities. In a study of total facility margins, the Government Accountability Office (GAO) found that Medicaid's share of patients in a facility influenced the overall margin: The higher the share of Medicaid patient days in a facility, the lower its total margins (GAO 2002).

If we were to consider total, rather than Medicare, margins in the Commission's payment adequacy analysis we would have to address two questions (1) whether Medicaid payment rates are adequate, and (2) whether Medicare should explicitly pay more than the cost of providing care for Medicare beneficiaries to subsidize lower payments from other payers. Evidence on the adequacy of Medicaid payments is limited and likely varies by state. One study found that after the repeal of the Boren amendment in 1998, which gave states greater latitude to set nursing home payment rates and was expected to lead to rate cuts by some, aggregate inflation-adjusted Medicaid payment rates rose steadily (Grabowski et al. 2004). This study also found that the baseline rates, as well as the growth in rates varied by state. A GAO study of 19 states' Medicaid nursing home rates found that in the period 1998 through 2004, nursing home payment rates were largely unaffected by the repeal of the Boren amendment, although a few states cut or froze nursing home rates (GAO 2003).[9] Both studies noted that nursing home payment rates could be affected by future state fiscal pressure. However, in its annual report on Medicaid budgets for state fiscal years 2006 and 2007, the Kaiser Commission on Medicaid and the Uninsured reported that state revenues continued to recover, "easing the imperative to implement major cost-containment measures" (Smith et al. 2006). One significant change that could affect nursing facilities noted in the report was that "a growing number of states are taking actions to balance their long-term care delivery systems by reducing reliance on institutional care and increase home and community based service options."

Regardless of the level of Medicaid payments, paying nursing facilities higher Medicare payments to compensate for any inadequacies in Medicaid payments would be inefficient and imprudent for the Medicare program. If Medicare were to pay still higher rates to subsidize low Medicaid payments, facilities with low Medicare shares and high Medicaid shares—presumably the facilities that need revenues the most—would receive the least if subsidies were provided in the form of higher Medicare payments. Given variation by state in the level and method of nursing homes' payments, a Medicare subsidy for Medicaid payment rates also raises the issue of how to equitably subsidize varying state Medicaid payments. In addition, states might be encouraged to reduce Medicaid payments, further increasing pressure to raise Medicare spending. ■

The large for-profit SNF providers appear to have good access to capital. The biggest concern related to Medicare payments for SNFs in the past year was the effect the RUG–III refinement would have on facilities' profitability and, in turn, the effect that would have on their ability to attract investors. According to analysts and industry reports, providers have successfully navigated the payment system refinements and are reporting increased profits over the previous year, largely due to increasing Medicare volume and case mix (Stifel Nicolaus 2006). We do not have specific information about access to capital for different categories of SNFs, such as how access differs for nonprofits versus for profits.

For large companies that access capital through private equity markets, industry analysts we interviewed believe the SNF sector may now have the best access to capital of the past 10 years. In general, they said that the risk of investing in this sector has declined and investors are finding this sector attractive. This is a function of several factors, including more discipline among providers, who were highly leveraged at the time the PPS for SNFs was implemented, resulting in several highly publicized bankruptcies in the late 1990s. Analysts said that providers have emerged from that period with much better cash flow positions. Among other factors they cited that make nursing facilities attractive to investors are:

- stability in the reimbursement environment, including RUG refinement and improving state fiscal situations, which mitigates the threat of Medicaid cuts (see text box);
- SNFs being well positioned to benefit from Medicare's efforts to rationalize the provision of post-acute care because they are the lowest cost institutional setting;
- increasing demand for short-stay SNF care as a result of the aging of the population; and,
- the interest of real estate investors in the nursing facility properties.

Although information on access to capital for publicly traded nursing home chains is relatively accessible through financial reports, information about transactions of the smaller chains and nonprofit facilities' access to capital is more difficult to obtain. To examine access to capital for smaller providers, we spoke with an analyst at a commercial lender who said that smaller providers in the SNF sector also have good access to capital because of the perception of a generally stable reimbursement environment. For smaller providers, capital is available but gets more expensive as the size of the operator and geographic area served get smaller because the investment appears riskier. Banks generally look more favorably on facilities with higher Medicare and private pay shares of days because Medicaid is considered less desirable from a reimbursement perspective, but this varies by state. In addition to commercial banks, specialized finance companies have emerged since the BBA to provide capital to long-term care providers. These entities are another source of capital for SNFs.

An overall picture of access to capital for SNFs also comes from the National Investment Center (NIC), a nonprofit that provides information about business strategy and capital formation for the senior living industry. NIC reported that key financial and operational indicators showed continued strength in seniors' housing, including SNFs. It reported that loan volumes for all sectors it tracks, including SNFs, were highest in the second quarter of 2006 than at any time since it began collecting data in 1999 (NIC 2006a). Loan performance has also been strong. The NIC noted caution moving forward because of interest rates, obsolescence of physical plants, and labor but also reported this year that it is a good time to be a borrower in senior care and housing (NIC 2006b).

Still another source of capital for nursing facilities is the federal government, which facilitates access to capital through a program operated by the Department of Housing and Urban Development (HUD). HUD's Section 232/223(f) program insures mortgages through HUD-approved lenders for construction and rehabilitation of nursing facilities and assisted living facilities. In fiscal year 2005, the programs insured new loans for nursing facilities totaling $821 million for 128 facilities (HUD 2005).

Payments and costs for 2007

The Medicare margin for freestanding SNFs has fluctuated over the past five years. It fell from 17.6 percent in 2001 to 10.8 percent in 2003, the year following the elimination of two temporary payment add-ons. Margins rose again to 13.7 percent in 2004 and then dipped slightly in 2005 to 12.9 percent (Table 3A-4, p. 178). We estimate that the Medicare margin for freestanding SNFs in 2007 will be 11 percent.

As we have seen in earlier years, the distribution of margins in 2005 shows wide variation in performance among freestanding SNFs as well as variation by groups. One-quarter of all freestanding SNFs had margins at or below 4.7 percent, but half of all facilities had Medicare margins of at least 15.5 percent, and one-quarter of SNFs had margins of nearly 25 percent or more. We also continue to see differences in margin distributions by type of facility, with half the for-profit facilities reporting Medicare margins of 18 percent or more, while half the nonprofit SNFs have margins of 9 percent or less.

When modeling 2007 payments and costs with 2005 data, we incorporate policy changes that went into effect in 2006 and 2007. We also take into account payment changes, other than the planned update, scheduled to be in effect in

TABLE 3A–4 **Freestanding skilled nursing facility Medicare margins**

Type of SNF	2001	2002	2003	2004	2005
All	17.6%	17.4%	10.8%	13.7%	12.9%
Urban	17.4	16.8	10.0	13.0	12.3
Rural	18.4	20.0	14.1	16.5	15.4
For profit	20.0	20.1	14.0	16.7	15.5
Nonprofit	10.2	8.9	1.3	4.0	4.5
Government	4.5	3.1	–6.8	–3.6	–5.4

Note: SNF (skilled nursing facility). Margins are calculated as payments minus costs, divided by payments for each group; margins are based on Medicare-allowable costs.

Source: MedPAC analysis of freestanding SNF cost reports, August 2006 file.

2008. This year's assessment of SNF payment adequacy occurs in the context of several changes to the payment system that were effective in 2006. These payment policy changes are:

- a full market basket update of 3.1 percent for fiscal year 2006;
- RUG–III refinement;
- the expiration of two temporary payment add-ons—the 6.7 percent add-on for the 14 rehabilitation RUG–IIIs and the 20 percent add-on for the 12 extensive care, special care, and clinically complex RUG–IIIs; and
- a provision in the Deficit Reduction Act of 2005 that reduces bad debt payment for Medicare beneficiaries from 100 percent to 70 percent; bad debt for dually eligible beneficiaries will still be reimbursed at 100 percent.

We also consider cost growth in recent years when modeling future costs. Cost growth (unadjusted for case mix) for all freestanding SNFs accelerated from 2004 to 2005 (Figure 3A-6). Some of this change may be due to shifts toward higher rehabilitation RUGs. Average ancillary cost growth has been greater than routine cost growth, which is consistent with shifting case mix toward higher payment therapy case-mix groups. Cost growth between 2002 and 2005 has shown different trends in for-profit and nonprofit facilities, with the average rate of growth declining in nonprofit SNFs but increasing in for-profit facilities.

The aggregate margin for hospital-based SNFs was –85 percent in 2005. Interpreting the negative aggregate Medicare margin for hospital-based SNFs is problematic because there is no conclusive evidence on the reason for the difference in average costs between hospital-based and freestanding SNFs. Allocation of overhead from the hospital may also account for a share of hospital-based SNFs' higher costs. Hospital-based SNFs may have higher cost structures or different practice patterns than freestanding nursing homes and may serve different patients. Underlying all of these potential explanations is uncertainty about whether higher costs of hospital-based SNFs result in clinical benefits or better quality. Comparison of quality across settings is confounded by poor case-mix measures and the potential for unobserved differences in patient characteristics in freestanding and hospital-based SNFs.

On average, hospital-based SNFs tend to serve largely Medicare beneficiaries and have a lower share of rehabilitation patients than freestanding SNFs. They also have shorter lengths of stay in the SNF and are more likely to use additional Medicare-covered post-acute care than patients in freestanding SNFs (Liu and Black 2003). These differences suggest that hospital-based SNFs may treat patients at an earlier stage in their post-acute care and may, in some cases, substitute for the end of an acute care stay rather than a freestanding SNF stay. More information about the entire episode of acute and post-acute care is

needed to appreciate the implications of differences in efficiency between episodes that include a stay in hospital-based and those that include freestanding SNFs.

Despite these general trends, the mix of patients at hospital-based SNFs is not uniform. On site visits with 15 hospital-based SNFs in 6 markets, we learned that those that have remained open described different ways of operating with respect to their SNF patient population:

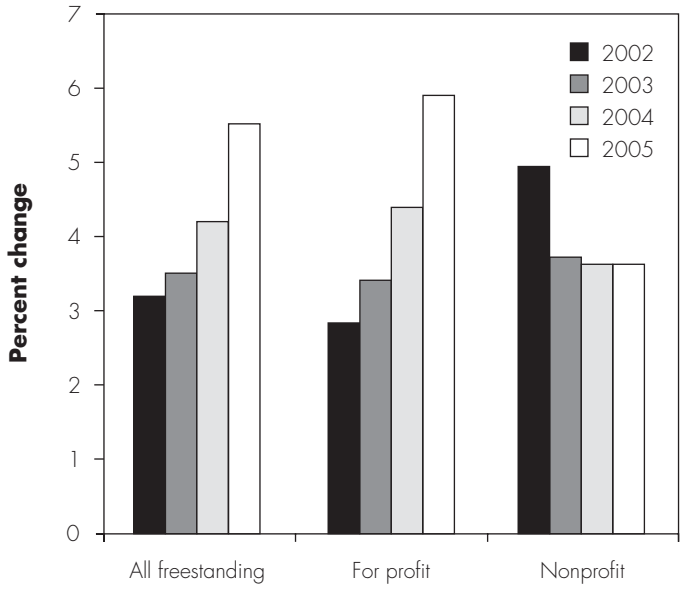
- selecting mostly Medicare patients who need rehabilitation services and are likely to be discharged home,
- selecting medically complex Medicare patients to shorten their hospital length of stay (LOS), and
- providing care to a small number of Medicare patients and a large number of long-term care residents. This model is similar to the general patient population in freestanding SNFs. Additional details on the site visits will be available from Liu and Jones (forthcoming).

These different approaches suggest that hospital-based SNFs select patients depending on how their SNF fits into the broader context of the hospitals' primary functions as acute care providers. On site visits, hospital officials said that they keep their hospital-based SNFs open in order to transfer some patients to the on-site SNF and thereby lower their inpatient LOS. The hospitals said they could not have transferred patients to freestanding SNFs as quickly. In some cases, hospitals said that other post-acute care providers did not have the ability or willingness to accept patients the hospital wanted to discharge.

Representatives from all of the hospitals on our site visits reported that certain types of patients are more difficult to place with post-acute care providers because of nursing care needs or costs of certain services that are not adequately reimbursed by the Medicare SNF per diem payment. In some cases, these patients may stay in the hospital longer. The representatives told us that Medicare payments for patients who receive rehabilitation services (physical, occupational, or speech-language pathology) make these patients very attractive. On the other hand, they consistently reported that Medicare payments are too low for patients who require intense skilled nursing care or a large amount of certain nontherapy ancillary services (e.g., IV medications, or ventilator care). The results from these site visits support previous findings that under the SNF PPS, rehabilitation patients are financially attractive, while certain medically complex patients are not.

FIGURE 3A–6

Growth in freestanding SNFs' costs per day is accelerating, but nonprofits show slowing growth



Note: SNF (skilled nursing facility). Costs per day are unadjusted for case mix.

Source: MedPAC analysis of freestanding SNF cost reports, August 2006 file.

Because medically complex patients are treated in all types of SNFs, the payment system should be improved to better account for these patients' costs regardless of the type of facility that treats them. Creating different base rates for hospital-based and freestanding SNFs moves payment policy further in the direction of payment based on facility type. This is counter to the Commission's broad goal of a payment system that bases payment on patient needs and characteristics regardless of the setting (see Chapter 3) and looks across episodes of care rather than within a single stop on the continuum of care. CMS is beginning to examine assessment tools and payments across post-acute settings. Other payment policy changes, such as improving the accuracy of the case-mix system or paying for quality, are consistent with the Commission's goal to pay for necessary, quality care delivered efficiently regardless of the setting.

How should Medicare payments change in 2008?

Indicators of payment adequacy suggest continued access to SNF care, but quality is a concern. The overall supply of providers remained stable in 2006, registering a small decline overall. SNF volume increased and more patients are categorized into higher payment therapy case-mix groups. Two measures of the quality of care for Medicare SNF patients suggest a trend of declining quality between 2000 and 2004. Analysis of SNFs' Medicare payments and costs found that payments will more than cover SNFs' costs of caring for Medicare patients in 2007.

Although evidence suggests that SNFs can more than accommodate the cost of caring for Medicare beneficiaries in 2008 without an increase in the base rate, the case-mix system appears to inadequately adjust for the costs of different types of patients. Specifically, the system creates incentives to select profitable rehabilitation patients and avoid unprofitable, medically complex patients. SNFs that care for more patients with expensive nonrehabilitation therapy needs may not be able to operate as profitably under the PPS for SNFs as those that care for a higher proportion of patients with short-term rehabilitation needs. A system that creates profitable and unprofitable patients needs to be better refined. The Commission will continue to explore ways to modify the case-mix system to better account for the costs of all types of SNF patients, thereby reducing incentives to avoid certain types of patients.

Given the decline in average facility quality scores in the midst of double-digit aggregate Medicare margins, increasing payments to all SNFs will not necessarily improve quality. Increasing the base rate for all SNFs is too blunt a mechanism to encourage quality improvement because facilities would receive payment regardless of their quality and therefore have no incentive to invest in efforts that improve quality. We will continue to investigate the level of and trends in facility quality scores. We are disaggregating below the national average to see whether, for example, certain facilities have different quality levels and trends over time and whether those are related to facility characteristics.

Update recommendation

SNFs should be able to accommodate cost changes in 2008 with the Medicare margin they have in 2007.

RECOMMENDATION 3A

The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2008.

RATIONALE 3A

The evidence indicates that Medicare beneficiaries continue to have access to SNF services. Under policies in current law for 2007 and 2008, we project the Medicare margin for freestanding SNFs will be 11 percent in fiscal year 2007. SNF payments appear more than adequate to accommodate cost growth; thus, no update is needed.

IMPLICATIONS 3A

Spending

- This recommendation reduces Medicare spending relative to current law by $250 million to $750 million for fiscal year 2008 and by $1 billion to $5 billion over five years.

Beneficiary and provider

- No adverse impact on beneficiary access is expected. This recommendation is not expected to affect providers' willingness and ability to provide care to Medicare beneficiaries. ■

Endnotes

1 A new spell of illness begins once a beneficiary has not had a hospital or SNF stay for 60 consecutive days.

2 These are diagnosis codes recorded at discharge from the hospital.

3 With approval from CMS, certain Medicare-certified hospitals—typically small, rural hospitals and critical access hospitals—may also provide skilled nursing services in the same hospital beds they use to provide acute care services. These are called swing bed hospitals. We do not include an analysis of swing beds in this report. On July 1, 2002, Medicare began paying swing bed hospitals that are not critical access hospitals according to the SNF PPS for SNF services. Critical access hospitals continue to be paid for care in their swing beds based on their costs.

4 The annual payment update was market basket minus 1 percentage point in fiscal years 2000 and 2001, and it was market basket minus 0.5 percentage point in fiscal years 2002 and 2003. In fiscal year 2004 and beyond, the updates to the base rate have been the full market basket amount. In 2004, SNFs also received a 3.26 percent increase to correct for cumulative market basket forecast error since implementation of the PPS.

5 Under the 44-group system, patients who qualified for both of these categories based on clinical characteristics would be paid the highest daily rate for which they qualified. Under the 53-group system, patients who qualify for both groups are paid under 1 of the 9 new categories, which are now the highest paid groups.

6 The case-mix system during both of these years was the 44-group RUG–III system. The 53-group system did not go into effect until January 1, 2006.

7 For more extensive discussion of the quality measures discussed in this section and a description of how they were developed and calculated, see the contractor report prepared for MedPAC by researchers at the University of Colorado Health Sciences Center available at http://www.medpac.gov/publications/contractor_reports/Sep06_SNF_CONTRACTOR.pdf.

8 These five conditions are not necessarily the conditions for which the patient was originally hospitalized or was treated in the SNF.

9 According to the GAO report: "Four of these states—Illinois, Massachusetts, Michigan, and Texas—cut the per diem rates paid to all nursing homes at some point, and in 2 of these states, the rate reduction was for less than 1 year. Two other states—Connecticut and Oregon—also froze nursing home per diem rates for a portion of this period" (GAO 2003).

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